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RUNNING HEAD: The Problem is My Partner

The Problem is My Partner: Treating Couples When One Partner Wants the Other to Change

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Abstract

Partners commonly present to couple therapy expecting that the relationship will only improve if their partner changes. In other words, the partner is the problem. In this paper we review research on people's capacity for change, the process of behavior change, and personality change, especially the role of attachment theory. We then review techniques for working with couples based on empirically validated approaches to couple therapy and general change principles in therapy. Finally, we present a case study and recommendations for working with change-demanding couples, emphasizing the importance of focusing on emotional acceptance.

Keywords: couple therapy, change, acceptance

The Problem is My Partner: Treating Couples When One Partner Wants the Other to Change

Clinicians who work with couples are faced with a variety of challenging problems and couple dynamics. Perhaps one of the most difficult (and common) is when one partner has identified the source of the problem as being located in the other and is demanding that the partner change. In this article, we address the question, "what do we as therapists do when one partner is insisting on change in the other?" In line with the goals of this special section, we discuss basic psychological research that bears upon the answer, with the goal of providing direction for intervention, as well as identifying questions in need of research.

The Problem

"I want my partner to change! If she/he was different, everything would be better and I would be happy!" This is what we hear from numerous couple members. So, the problem, then, is the desire for partner change, but what does "partner change" really mean for couples?

Often partners have identified a specific behavior they would like changed. This might be a habit that bothers them, like making plans without consulting the other person. It might be related to the division of household tasks, the way their partners communicate, health behaviors, levels of intimacy, spending more time together, or providing more emotional support. Indeed, research shows that such requests are among the most common problems that couple therapists see: communication, power struggles, unrealistic expectations of partner, demonstrations of affection, sex, money-management, serious individual problems, and household management (Whisman, Dixon, & Johnson, 1997).

Partners also often identify personality styles or other individual characteristics they want changed. They may complain that their partner is too emotional or neurotic, or too cold and dismissive. They may be unhappy with their partner's depression, anxiety, or anger and how

their partner expresses and manages those feelings. They may see their partner as too needy and demanding, or too distant and self-sufficient. Indeed, there are many personal characteristics that people label as character flaws in their partners that they would like changed.

Of course, personal characteristics and specific behaviors can go hand-in-hand. Partners regularly say things like, “I want my partner to spend more time with me, but she/he won’t because she/he’s a cold, distant person with no feelings!” It is our job as couple therapists to ascertain whether this is really true – does the specific behavior reflect a broader personality trait or emotional state? It certainly may. For example, we know that when people feel depressed they become withdrawn, less interested in having sex, and may gain weight. As another example, someone with a more avoidant attachment style – who has difficulty feeling comfortable with intimacy and prefers to be more distant – will be less likely to and less effective at providing emotional support (e.g., Davila & Kashy, 2009). On the other hand, the partner desiring change may be falling prey to the fundamental attribution error (Jones & Harris, 1967), which is the bias of attributing other's behavior to internal causes – so, irritating behaviors are interpreted as annoying personality traits. Therefore, one of the first things that the couple therapist needs to assess is exactly what change is desired. The next thing will be to assess the extent to which that behavior or characteristic is changeable, an issue to which we now turn.

The Research Findings

Can people change? And if so, how much? These are important questions for all therapists, and particularly for the couple therapist dealing with one partner demanding change in the other. So, what do the data tell us?

How much can people change?

Personality stability. Data on personality stability provides important information for understanding the capacity for change. There is good news and bad news. The bad news, at least for the partner desiring change, is that a good deal of data point to the fact that personality, be it normal traits or personality disorder, is quite stable. A recent meta-analysis (Ferguson, 2010) found the rank-order stability coefficient to be .60 across studies that included general personality traits (e.g., neuroticism, extraversion, openness, conscientiousness, agreeableness), non-general traits (e.g., aggressiveness, religiosity), and personality disorders. This meta-analysis also found that stability coefficients increase with age and do not differ for the three types of personality variables, men and women, and clinical vs. non-clinical samples. The bad news also is that people select into stability-promoting environments, which then reinforces existing personality traits (e.g., Caspi, Roberts, & Shiner, 2005; Hopwood et al., 2011). And if that was not bad enough, behaving in a way that is contrary to one's typical trait-driven behaviors is effortful and demanding, and fatigue from trying to do so may result in a return to trait-consistent behavior (Gallagher, Fleeson, & Holye, 2010). So, change is hard – not a big surprise for us as clinicians, but it might be a surprise and a disappointment for clients who so desperately want their partners to change.

The good news is that change is possible. A number of large-scale studies of personality traits over the course of adulthood have found that change occurs, and it does so in response to environmental factors. For instance, in a twin study, Hopwood et al. (2011) found that negative emotionality could increase or decrease based on non-shared environmental influences (i.e., environmental circumstances that are unique to each twin). Specht, Egloff, and Schmukle. (2011) found that trait levels changed following major life events, such as marriage and divorce.

Dweck (2008) has theorized that belief systems are part of the foundation of personality because they drive experience and behavior in consistent ways over time. As such, if belief systems can be changed, experience and behavior change will follow. Therefore, targeting beliefs may be a specific way to bring about “personality” change and increase adaptive functioning. Indeed, research supports this. For example, Dweck and colleagues (see Dweck 2008 for a review) have found they can change people’s beliefs about how malleable their intelligence is, and when people make such changes they perform better academically.

Attachment stability. The literature on stability in attachment security echoes personality findings and is particularly relevant for interpersonal change in the couple context. Attachment theory suggests, and research confirms, that working models of relationships developed in the parent-child relationship are carried forward and guide interpersonal functioning over the life course (see Mikulincer & Shaver, 2007). Romantic relationships are primary attachment relationships in adulthood, and attachment dynamics often underlie relational problems (see Johnson & Denton, 2002). In adulthood, attachment is characterized by the extent to which people feel avoidant of intimacy and anxious about abandonment in their relationship with their partner. Greater avoidance and greater abandonment anxiety reflect insecurity, whereas greater comfort with intimacy and confidence in the partner’s availability (i.e., lower abandonment anxiety) reflect security. Although attachment avoidance and anxiety are relatively stable in adulthood, change results from salient and emotionally significant intra- and interpersonal experiences, including major life events (e.g., marriage; Davila, Karney, & Bradbury, 1999), day-to-day relationship experiences (e.g., conflict; Davila & Cobb, 2003), and the meaning that people attach to their experiences (e.g., feelings of loss in response to an event; Davila & Sargent, 2003).

Thus, although change is not the norm and is difficult to effect, change can come about in relation to new intra- and interpersonal experiences. Indeed, the attachment and personality findings bode well for couple therapy and suggest that helping couples have new experiences individually and with one another, as well as helping them develop new beliefs and attributions about their experiences may increase the chances for change.

It is important to note that the ability to change is restricted due to the genetic underpinnings of personality and interpersonal behavior (see Caspi et al., 2005). Helping clients understand this and what it means for their relationship will be important. For example, a person with a behaviorally inhibited temperament is never going to be an extravert, but s/he might become somewhat more outgoing. Talking directly with clients about these ideas will likely be necessary.

Gender, culture, and change. Is the likelihood of change affected by a person's gender, ethnicity, or culture? Research suggests that it is not; likelihood of change appears to be similar for men and women, people of various ethnic backgrounds, and people in various cultures (e.g., collectivist and individualist cultures; McCrae & Costa, 2006).

There is considerable evidence, however, that desire for change in a partner as well as resistance to change attempts by a partner are related to gender and social structure (Eldridge & Christensen, 2002). Women are more likely than men to desire and press for change in part because men are more satisfied with their relationships (in studies of married couples husbands consistently report higher satisfaction than wives; Fowers, 1991) and because they benefit more from relationships than women (Bianchi, Milkie, Sayer, & Robinson, 2000). For example, despite dramatic increases in the number of women who work outside the home, women are still responsible for the majority of household work and childcare. In a daily diary study of 6,740

men and women and a 10-year national survey of over 4,000 couples, Bianchi and colleagues found that marriage leads to a 5-hour per week increase in women's household work hours and no increase in men's. Further, having children under 12 increases wives' hours spent on housework more than three times the increase in husbands' hours (Bianchi et al., 2000).

In addition to being more likely to press for change, women recognize relationship problems and the need for counseling earlier, and are typically the ones who initiate contact with practitioners (Doss, Atkins, & Christensen, 2003). During couple therapy, women are more likely to demand change and to be more vocal about problems compared to men, whereas men are more likely to withdraw to maintain the status quo. Interestingly, the imbalances in household work and childcare, and subsequent gender-related demand/withdrawal behaviors take place even when husbands and wives desire an egalitarian relationship, especially after they become parents (Cowan & Cowan, 2000).

Behavior change. We all know the old joke: "How many therapists does it take to change a light bulb? Only one, but the light bulb has to want to change!" The truth is that this is no joke. The literature bears this out – if people do not want to change a behavior their partner is complaining about, they probably won't. Indeed, change happens in stages. Prochaska and DiClemente (2005) developed the transtheoretical model of change (TTM) which proposes four stages of change: (1) Precontemplation – there is no intention to change and the person may be unaware that problems exist and that change is needed or desired by others; (2) Contemplation – the person is aware that a problem exists and is seriously considering that change may be necessary, but no steps have been taken; (3) Action – the person is implementing changes; (4) Maintenance – the person is working to consolidate gains and prevent relapse to problem

behavior. As this model implies, change will not happen if people are in precontemplation. Therefore, an initial goal of therapy is to help couples/partners move to the action phase.

Research on helping individuals move forward in the stages of change may be helpful with change-seeking couples. One of the most well-developed and effective approaches is Motivational Interviewing (Miller & Rollnick, 2002). Motivational Interviewing (MI) focuses on exploring and resolving ambivalence about changing behavior and supports change in a manner congruent with the person's own values and concerns. The approach involves expressing empathy such that the client experiences the therapist as able to see the world as she/he sees it, supporting self-efficacy by focusing on previous successes, highlighting skills and strengths, rolling with resistance, and helping clients examine discrepancies between their current circumstances and their values and future goals. The primary techniques used are open-ended questions, affirmations, reflections and summaries. Therapists also elicit change talk; for example, asking about pros and cons of changing and staying the same, and asking about positives and negatives of the alternative behavior.

Although MI works well in individual therapy, attempting to use it in couple therapy can be tricky, especially when there is a history of the partner unsuccessfully trying to get the other to change. Research indicates that in some cases a partner can be effective in helping an individual move toward change and thus may serve as an ally in promoting change (Lewis & Butterfield, 2007). In these cases, using MI techniques in the presence of the partner may be useful. Unfortunately there also is evidence that successful change attempts by partners can have unwanted side effects on partners making a change and on the relationship (Lewis & Rook, 1999). The complaining partner may get the desired change, but at the cost of emotional distress to the partner and decreased relationship satisfaction. In these cases, MI might have the added

benefit of modeling optimal techniques for the change-seeking partner, such as expressing empathy and using affirmations that may mitigate potential emotional and relational distress.

Further, research indicates that positive change attempts made by a partner (e.g., discussing) lead to an increased likelihood of positive behavior change, whereas negative change attempts (e.g., nagging, complaining) lead to changes in the opposite direction (Tucker & Anders, 2001). In addition, stylistic differences in change attempts can matter depending on the interpersonal style of the partner who is the target of change. Overall, Simpson, and Struthers (2013) observed couples discussing an issue in which one partner wanted change in the other. On average, people higher on avoidant attachment showed anger and withdrawal when they were the target of their partner's influence, and this was associated with less successful discussions. However, when partners used softening strategies (e.g., communicated care, validation, and optimism), their avoidant partners demonstrated less anger and withdrawal, and discussions were more successful. Helping partners learn how to make positive and stylistically sensitive change attempts in couple therapy may be very helpful.

There may be times, however, when change work in couple therapy may not be a good idea. Some studies on partner change attempts have reported negative effects. For example, Franks and colleagues (2006) found that, over 6 months, spouses who experienced more change attempts reported decreases in health behaviors and worsening mental health (Franks, Stephens, Rook, Franklin, Keteyian, & Artinian, 2006). The difficulty in predicting whether or not change attempts will succeed is underscored by qualitative findings that the strategy “requesting the spouse to engage in a health-related behavior” was one of the top three effective strategies, but “this strategy was also the most frequently mentioned *ineffective* strategy by husbands and

wives” (Tucker & Mueller, 2000, p. 1125). Thus working toward change with a client in couple therapy might be counterproductive to change and may make matters worse between the couple.

So how do we know to what extent we should involve (or try to reduce involvement by) a partner when we decide it is important to work with one member of a couple on making a change? Should we meet with the client individually for a few sessions? Should we refer the client to an individual therapist? Research suggests that the accuracy with which partners gauge the others’ readiness to change, and their skills in using strategies optimal to the current stage of change, may be critical to partner response to change attempts. For example, bringing home Nicorette gum to a partner in the precontemplation stage of smoking cessation is likely to be far less successful than bringing home gum to a partner in the action phase. Unfortunately partners are not particularly good at either assessing the stage of change or selecting optimal strategies. In fact, partners who desire change tend to overestimate how ready their partners are and more often choose less than optimal strategies (Sullivan, Pasch, Bejanyan, & Hanson, 2010).

The decision of whether to work on individual behavior change in couple therapy, therefore, needs to take into account 1) the client’s current stage of change, 2) the partner’s perception of the current stage of change, and 3) the history of change attempts and their impact. The most challenging, and most likely, scenario is working with a client in the precontemplation or contemplation stage with a history of negative change attempts by the partner that have increased resistance to change. In this case, the therapist must contend with two additional difficulties: first, any intrinsic desire to change may have been lost as a result of feeling pushed before being ready and, second, what was once an individual issue is now couple issue as well. In these cases, change work in couple therapy is likely contraindicated. In fact, removing that

partner completely from the process of promoting change, at least at the beginning, may optimize the chance of change and protect the relationship.

How much change is evident in couple therapy?

Research on couple therapy outcomes. We couple therapists know that, although couple therapy *can* help, many couples who seek treatment show little to no improvement or fail to sustain gains over time. Outcome research over the past three decades is consistent with therapists' experiences; approximately 25–30% of couples do not improve and another 30% improve somewhat, but still report significant distress after treatment (Halford, Hayes, Christensen, Lambert, Baucom, & Atkins, 2012). Further, among couples who do improve, there is substantial relapse over the next few years (Snyder, Mangrum, & Wills, 1993). Below we briefly review current empirically supported treatments and discuss specific techniques that can be derived from them to help couples desiring change.

Traditional Behavior Couple Therapy (TBCT; Jacobson & Margolin, 1979) focuses on behavior change using the following techniques. *Behavior exchanges* involve each partner making a change and making those changes contingent on one another. For example, a spouse will agree to clean up after dinner *if* her partner cooks dinner and her partner will agree to cook dinner *if* the spouse cleaned up the night before. This technique is most effective when therapists begin with changes that are relatively easy to make and that partners value. *Communication skills training* also may be useful by helping partners articulate their desire for and/or resistance to change in a less provoking way (e.g., using “I” statements and active listening). *Problem-solving skills*, such as making a list of all possible solutions before deciding together on one, may help couples think creatively about managing difficulties.

Cognitive Behavioral Couple Therapy (CBCT; Baucom, Epstein, Sayers, & Sher, 1989), targets underlying thoughts and assumptions that fuel distress. This involves addressing couples' interpretations of relationship events, inaccurate assumptions ("men are lazy"), irrational standards ("you should know what I mean without me having to explain it"), negative selective attention ("you never kiss me when you come home"), and misplaced attributions ("you don't talk to me about your work because you think I'm stupid").

Emotionally Focused Couple Therapy (EFT; Johnson & Greenberg, 1987) and Insight-Oriented Couple Therapy (IOCT; Snyder & Wills, 1989) represent alternatives to focusing directly on change; in EFT, therapists emphasize the attachment between partners, encouraging partners to embrace their feelings, validate each other's emotions ("Wow, if that happened to me I would feel really angry too") and provide the expected comfort when their partner is distressed. IOCT therapists focus on gaining insight into unconscious conflicts, exploring the meanings clients assign to events and encouraging feeling emotions more deeply. They use reflection ("So you feel abandoned and a bit desperate when he leaves during a fight") and "affective reconstruction" to connect current emotions and conflicts to underlying dynamics ("When he leaves it makes you feel like you are once again the young girl who was aching for attention and love from her parents"; Wills, Levin, & Snyder, 1987).

Integrated Behavior Couple Therapy (IBCT) integrates elements from multiple approaches with a focus on increasing empathy for partners so they can respond to one another in a more accepting way, thereby promoting an atmosphere more conducive to naturally reinforcing behavior change. Techniques used to facilitate emotional acceptance and empathy are described in detail below, in the section "Are there alternatives to change?" Before we describe alternative

approaches, however, we first discuss general principles of change in the context of couple therapy

General principles of change in couple therapy

The primary strategies used to effect change in couple therapy, as described in the prior section, have largely been well researched and many have clear roots in basic theory and research in the areas of learning and behavior, cognitive and attribution processes, and attachment theory. No matter what particular therapy is utilized, they all share common elements that are reflected in general principles of change (Norcross, 2011). We review these with an eye towards how they apply to couple therapy.

Optimizing expectations that therapy will help. There are many challenges for couple therapists in fostering positive expectations that therapy will help. Couples often come to therapy when they are very distressed and some have given up altogether, coming only to make exiting the relationship smoother. Even for couples whose relationship is fairly stable, there may be little or no hope that changes they desire will be realized. Because of this, it is especially important for therapists to immediately begin working toward fostering at least a minimal level of motivation and optimism, using strategies such as highlighting strengths, goal setting, and psychoeducation about the effectiveness of therapy. One strategy that works well is to ask partners to tell the story of how they met, fell in love, and decided to commit. Such reminiscence can help to foster hope that things can get better in the relationship.

Establishing a strong therapeutic alliance. The facilitation of an optimal therapeutic alliance in couple therapy is challenging in that a personal bond must be created with each partner, and one partner must not feel the therapist is on the other person's "side". To facilitate this, therapists must take special care, especially in the beginning of therapy, to make the time

and attention devoted to each partner about equal, and to use techniques (e.g., reflections) that communicate empathy for each partner's positions and perceptions.

Use of feedback to increase client awareness. There is substantial evidence that feedback is an essential component for therapeutic change (e.g., Owen, Duncan, Anker, & Sparks, 2012). A key challenge to the use of feedback with couples is partners' defensiveness about receiving feedback and processing it in the presence of the other. Partners may be concerned that acknowledging personal issues will provide fodder for future conflicts. Thus, special attention must be paid to the timing and context of feedback and increasing awareness. Skilled use of feedback in front of the partner, however, may help increase hopefulness in the partner desiring change. This can be done by increasing awareness in a way that conveys understanding and empathy without blame, helping the partner desiring change to become more empathic and understanding.

Promoting corrective experiences. Corrective experiences involve clients engaging in behavior that they typically avoid because they expect something negative will happen and instead experience something positive. Perhaps the most fundamental way therapists create the environment for corrective experiences with couples is to ensure that conflict discussions in therapy are different from those experienced at home. Instead of having conflict lead to arguments, negative feelings and mutual avoidance, the couple can learn and practice new skills for successful negotiation. Couple therapists may accomplish this in a number of ways, including communication training, problem-solving training, increasing empathy, facilitating emotional joining around the problem and promoting acceptance. Experiencing new, more successful ways of handling problems with their partner helps couples feel more satisfied and more confident about dealing with challenges. Trust and a sense of working together as a team replaces criticism

and defensiveness, improving the relationship and increasing the chance of making and maintaining individual behavior change.

Emphasizing ongoing reality testing. This involves an ongoing process in which increased awareness leads to corrective experiences, which then provide evidence for further awareness, and so forth. It is through this process that changes or gains made in therapy are solidified in the couple's life. It requires the couple to practice what they learned, being prepared for stressors or problems, and being aware of how to deal with them effectively using new skills. Tapering of therapy, or booster sessions, may help couples continue to enact new behaviors, as well as trouble-shoot issues .

Are there alternatives to change?

As we have noted, change may not always be possible in couple therapy. Indeed, some forms of therapy (e.g., Integrative Behavioral Couple Therapy) explicitly take the focus away from change and onto acceptance. However, because strategies for handling situations where change may not be possible have been of less focus in the literature – we are therapists after all and want to help people change! – as couple therapists we may not believe it is acceptable to work on acceptance rather than change, and we may not be aware of the evidence that supports acceptance-based goals.

The rationale for acceptance. Ironically, sometimes the best way for a partner to effect change in the other is to stop trying. Consider Mario and Emily. Mario came to couple therapy because he wanted Emily to engage in sex more frequently; Emily wanted more frequent non-sexual expressions of affection, such as a kiss when she returned from work. Mario resented her requests because he felt he was not getting his sexual needs met; unfortunately the decrease in sex was due in part to his ongoing requests and pressure to engage in sex. A therapist might

approach their problems by encouraging change, perhaps brokering a deal whereby Mario agrees to kiss Emily when she returns home and Emily agrees to have sex a certain number of times per week.

There are several reasons therapist-prescribed changes such as this may not work. First, prescribing behavior change may increase resistance. In Emily's case, the pressure to engage in sex more frequently caused her to feel guilty, resulting in a decrease in overall sexual desire. Second, prescribed behavior feels different than spontaneous or naturally occurring behavior. The couple may find the prescribed kissing and sex less satisfying than physical affection that occurs spontaneously. Third, Emily and Mario are more likely to interpret kisses after work or sexual engagement as something the other is doing because he or she is living up to the "deal" rather than spontaneously desiring physical affection (Dimidjian, Martell, & Christensen, 2008). On the other hand, increasing empathy for each other's experience and acceptance of each other's needs and desires as natural and normal may result in the spontaneous increases in affection both desire. Focusing on empathy and acceptance rather than prescribed behavior change is likely to be an effective alternative.

The evidence base. Acceptance-based interventions were integrated into the behavioral approach used in Integrative Behavior Couple Therapy as a way to move towards the building of natural rather than arbitrary reinforcement for behavior. Arbitrary reinforcement refers to consequences provided by the therapist that do not exist in the client's natural environment or that do not naturally arise from the couple interaction (Ferster, 1967). Arbitrary reinforcement can, therefore, be experienced by the couple as false or manipulative, and can generate resistance. Moreover, as Koerner, Jacobson, and Christensen (1994) note, arbitrary

reinforcement can reduce intimacy in couples because it may lead to behavior being perceived as based on a rule and insincere.

In the case of Mario and Emily, increasing Mario's emotional acceptance of Emily's lower sex drive, and thus relieving pressure for more frequent sex, may free Emily to initiate sex more frequently and become a more enthusiastic sexual partner. This process is consistent with what we know about motivation for behavior. Compared to external/controlled motivation, internal/autonomous motivation is associated with better performance and greater psychological well-being across numerous domains (Deci & Ryan, 2008). Furthermore, according to Self Determination Theory (e.g., Ryan & Deci, 2000), "...autonomy for behavior is facilitated insofar as actors are helped to identify their own reasons for changing their behavior and do not feel pressured or manipulated toward certain outcomes. In fact, the more the person "owns" the reasons for changing, the more autonomous and therefore the more likely to succeed is the behavior change" (Ryan, Lynch, Vansteenkiste, & Deci, 2011, p. 231). Autonomous motivation is undermined when a person feels pressured or controlled by an intimate partner, (see Deci & Ryan, 2008), whereas positive regard, caring, and understanding provide greater support for autonomous motivation (Ryan et al., 2011). Thus, when Mario pressures Emily for sex, she loses sight of herself and her own sexual desires and is less motivated to make changes. If Mario can instead develop a better understanding of Emily's sexual self and greater acceptance of that self, Emily may shift from reacting to Mario to owning her own sexual needs and may become motivated to make some changes.

Research examining direct links between acceptance-based interventions and their expected outcomes is needed and has only just begun. There is one study, however, that demonstrates that acceptance of partner behavior (both positive and negative) is associated with

greater marital satisfaction. Further, acceptance mediates the association between partner behavior and satisfaction, suggesting that the effect of partner behavior on one's satisfaction depends on one's acceptance of that behavior (South, Doss, & Christensen, 2010). In addition, acceptance mediated the association between partner behavior and one's own behavior, such that greater acceptance was associated with less negative and greater positive reciprocity of behavior (South et al., 2010).

Empathic joining and unified detachment. Jacobson and Christensen (1996) emphasize two techniques that serve to increase acceptance. The first, "empathic joining," occurs when partners understand more fully the background and personal vulnerabilities that underlie the others' position. When partners are able to gain increased empathy for the other's experiences, they are more likely to spontaneously and lovingly try to meet each other's needs. This process is consistent with the literature on empathic accuracy (the ability to infer a partner's thoughts and feelings), which shows that couples who are more empathically accurate tend to accommodate one another more and feel more committed to the relationship (for a review see Rollings, Cuperman, & Ickes, 2011). Although these findings have emerged primarily among newly married couples, in couple therapy the "re-emergence" of empathic accuracy, particularly around partners' vulnerable, "soft" feelings, may create a new found desire to accommodate the partner and feel committed to the relationship.

The second technique, "unified detachment," occurs when the couple is able to relocate the problem from within to outside the couple. The problem is seen as "over there" and the two unite to tackle the problem rather than blame one another for it. So, for Mario and Emily, the problem changes from "your sex drive is too high" and "your sex drive is too low" to "Huh, we have a problem, we're in a relationship wherein one of us has a higher sex drive than the other".

Conceptualizing the problem this way, the couple is more able to emotionally detach from the problem and work together to find ways to optimize both partners' needs getting met. Indeed, the ability to recognize that both people in a relationship have needs that deserve to get met, and the willingness to search for solutions that attempt to incorporate the needs of both, are at the foundation of adaptive interpersonal problem solving (e.g., Selman, Beardslee, Schultz, Krupa, & Podorefsky, 1986).

Conclusion. The answer to the question “Are there alternatives to change” is yes, and it is clear that the use of acceptance-based interventions is not only acceptable but supported by theory, research and clinical experience. Successful acceptance-based interventions help re-locate the problem from the partner, increase empathy, and help couples feel better about their relationships. Paradoxically, acceptance-based interventions may even produce desired behavior changes by setting the stage for spontaneous change and naturally-occurring reinforcers.

Clinical Example

Drawing on our work with couples, we now describe a hypothetical case, based on a number of couples we have treated, in which both partners were demanding change in the other. Dan and Lauren presented to couples therapy on the verge of divorce. They had been married for 11 years and had two school-age children. Both were business professionals. They reported frequent and intense arguing that included verbally (but not physically) aggressive behavior. Both were extremely angry and blamed the other for the problems. Dan described Lauren as hostile and critical and excessively emotionally reactive. Lauren described Dan as cold, non-communicative, and dismissing. Both wanted the other to change.

Note that this is common in couple therapy. Partners may have very different, seemingly opposite, interpersonal styles that serve to exacerbate each other's areas of vulnerability and,

over time, polarize even further as conflicts become more frequent. The literature on the demand-withdraw pattern in couples (Eldridge & Christensen, 2002), as well as that on attachment patterns in couples (see Mikulincer & Shaver, 2007) reflect this. In addition, interpersonal styles may interact in ways that reduce effective functioning. For example, among couples where the husband is avoidant of intimacy and the wife is anxious about abandonment, husbands have difficulty approaching wives for support and wives have difficulty recognizing husbands' distress (Beck, Pietromonaco, DeBuse, Powers, & Sayer, 2013).

During the course of therapy, it became clear that Lauren did have a tendency toward emotional reactivity, and that Dan tended towards emotional constriction, a dynamic that polarized them. It also became clear that, whereas Lauren could admit her behavior was problematic and she was open to change, Dan neither saw his behavior as a problem, nor was he open to change. It also became clear that Dan's style was quite ingrained and likely only changeable within a narrow range. Lauren, however, seemed capable of engaging in a wider range of emotion regulation strategies and interpersonal behavior. This presented an interesting dilemma – how to support change in Lauren when it was clear that Dan was not going to change. She would need to work on acceptance, as would Dan, but he also was reaping the benefits of Lauren making changes. In the end, this dilemma did get in the way of Lauren and Dan making progress, as Lauren was frustrated by Dan's inability for change, though they did reduce the frequency and intensity of their conflicts and decided to stay together. The focus on acceptance work enabled both partners to understand better why each behaved the way they did, and develop some empathy for one another.

For example, Dan grew up in a very unemotional family where logic predominated. Displays of intense emotion were foreign and frightening to him. They led him to feel judged

and to assume that the relationship was at a breaking point. When he was able to express this to Lauren, rather than criticizing her, she developed a new understanding of his reaction and the impact her behavior had on him. This helped her to be willing to modify her behavior with him.

Lauren's family was extremely emotional. Yelling and intense displays of affect were the norm, and no one thought much of them. So for Lauren, such behavior was not something to be alarmed by and certainly did not mean, to her, that the relationship was in danger. As Dan could understand this, he felt less threatened by her emotional reactivity, though it still felt quite uncomfortable to him.

Lauren also was able to see the personal benefits of learning to better regulate her emotions, and, as she did, she developed a more internal/autonomous motivation for change. This helped quite a bit in dealing with the dilemma noted above because she was able to feel as if she was changing for the better for herself.

In the end, the couple did make attempts to be more accommodating and certainly increased their commitment to the relationship, but at the end of treatment they were both still struggling with acceptance, though they were aware it was the only way for them to go forward.

Concluding Comments

There is strong theory, clinical observation, and research that support a focus on acceptance in couple therapy. There also is promising therapy outcome research showing the efficacy of treatments that include acceptance-based interventions. However, there is very little research on the process of acceptance itself, and it is this issue that should be a primary focus of future research. Not only should research continue to focus on whether acceptance is associated with the specific types of changes it purports to be (as was examined in the South et al., 2010 study), it should focus on two additional sets of questions. First, how capable are people of being

accepting? The interventions assume that people are capable of acceptance, but the extent of people's capacity, the internal processes by which people sustain acceptance, and the circumstances (including partner behaviors) that promote capacity for acceptance are not clear. Second, what qualities in a person or a relationship make acceptance easier or harder? Knowing for whom acceptance-based interventions are most and least likely to work will be an important next step for providing couples with the treatments that are most likely to be successful for them.

In sum, the conviction that the problem is the partner and that the partner has to change is a common and challenging issue for therapists treating couples. When faced with this issue, we recommend the following:

- Assess exactly what needs to change.
- Assess its “changeability” – is it a trait or a behavior and how ingrained is it? Are there cultural or gender-based barriers to change? Does the partner want to change, and at what stage of change is s/he?
- Make partners aware that change, while possible, can be difficult – and remember that they will not like hearing this!
- If it appears that individual change is possible, assess whether partners are likely to be a positive force for change or an impediment to change and make therapeutic decisions accordingly.
- Use an acceptance-based approach when change is not possible. Remember, too often couples leave therapy without significant gains, or gains that do not last over time.

Acceptance techniques show promise in helping clients to reframe problematic partner behavior as understandable or at least tolerable and to work together as a team to get both partners needs met.

- Even when change is possible, attempt to help the partners develop empathy for one another, help them join around the problem, and foster internal/autonomous motivation by not setting up too many therapist-prescribed changes.
- And whether the focus is on change or acceptance – or both – helping the couple shift from “the problem is my partner” to “the problem is the problem” will be a helpful shift.

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